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Risk Factors and Interventions for Suicide Among College Students

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Risk Factors and Interventions for Suicide

Among College Students

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requirements for the Master of Science Degree in

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CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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Suicide and Suicide Risks in College Students:

Predictors and Interventions

This is to certify that the Capstone Project of

Amy McAulay

Has been approved by the faculty advisor and the CE 695 – Capstone Project

Course Instructor in partial fulfillment of the requirements for the

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Abstract

According to the Center for Disease Control (2016), suicide is the third leading cause of death among 15 to 24 year olds in the United States. Research indicates that the rate for suicide among college students is seven to eight students per 100,000 college students (Cimini & Rivero, 2013). Suicide in college students is a great concern of campus counselors, student affairs administrators, and chief executive officers. However, the responses of colleges and universities to student suicides have changed over time (Brandt-Brown, 2014). In the past, college campuses focused on a standard clinical intervention strategy, which focused on preventing suicide through traditional mental health services. Currently, campuses are incorporating more proactive, problem-solving strategies to their suicide prevention efforts (Brandt-Brown, 2014). This paper will (a) describe a variety of risk factors and warning signs; (b) define different campus intervention strategies; (c) outline post-suicide interventions.

Keywords: suicide, college students, risk factors, warning signs, prevention.

Contents

Introduction

Students across the United States are coming to colleges and universities with

increasingly complex mental health issues, including histories of psychological and psychiatric

conditions that may be associated with elevated risk for suicide (Cimini, Rivero, Bernier,

Stanley, Murray, Anderson, & Bapat, 2014). Risk for suicide among college students is a major

public health concern that affects institutions of higher education across the nation (Cimini &

Rivero, 2013). According to the U.S. Department of Health and Human Services, suicide is

defined as deliberate and fatal self- harm with the presence of some intent to die as a result of the

behavior (Whisenhunt, Chang, Brack, Orr, Adams, Paige, & O'Hara, 2015). Suicide is the

second-leading cause of death among college students, and it is estimated that 1,088 college

students die by suicide each year (Taub & Thompson, 2013). It is estimated that the rate of

attempted suicide is somewhere between 100 and 200 for every complete suicide (Taub &

Thompson, 2013).

A suicide attempt is a non-fatal, self-inflicted, injurious behavior with the intent to die as

a result. Approximately 61.0% of persons who attempt suicide seek medical attention. Thus, the

rates of suicide attempts cannot be definitively calculated (Whisenhunt et al., 2015). A suicide

attempt differs from self-injury in that self-injuries are a purposeful act of self-harm that is not

done for body modification or adornment. Self-injury involves tissue damage without the

conscious intention to die as a result of the self-harm act (DeShong, Tucker, O'Keefe, Mullins-

Sweatt, & Wingate, 2015).

Suicides, suicide attempts, and self-injury in college students in the United States have

been a concern of campus student affairs administrators and chief executive officers, however,

the responses of colleges and universities to student suicides have changed over time (Brandt-

Brown, 2014). In the past, student suicide was considered a national problem, but not a problem on local campuses. During the early 20th Century, a standard was colleges or universities responded to suicide attempts or threats was a technique labeled watchful waiting and hospitalization. If there was a suicide attempt, a policeman or doctor would be called and the student would be transferred to an institution to receive medical help. If a suicide attempt was not made, the only plan in place was to be watchful and wait (Brandt-Brown, 2014).

As America moved into the 21st Century, the problem of suicide on college campuses did not go away. As a result of the continued loss of life, colleges and universities evolved their strategies to combat the problem. Part of the impetus to change was fueled by multiple lawsuits involving colleges and universities (Brandt-Brown, 2014). In addition, from 1999 a series of mass shootings afflicted the United States. Many of these mass shootings ended with the shooter either with suicide by cop or committing suicide upon themselves with their own gun. The prevalence of lawsuits and mass shooting heightened the awareness that all individuals on campus needed to know the signs of mental distress and what to do when people exhibit these signs (Brandt-Brown, 2014).

Review of Literature

Research has identified a number of risk factors and warning signs associated with suicide. Because most students who die by suicide had never received counseling services, broader campus prevention efforts are critically important in reaching students who may never seek support services for themselves (Cimini et al., 2014). It is no longer acceptable for colleges to wait until a crisis to happen. Colleges must be proactive to support their student's mental health, otherwise the campus will be left dealing with a tragedy. There are a variety of different

prevention strategies a college may choose that include identifying risk factors, psychoeducational interventions, community outreach, counseling, and much more.

Risk Factors and Warning Signs

When discussing suicide, it is important to differentiate between risk factors and warning signs. factors for suicide are characteristics that make it more likely that a person will think about suicide or attempt suicide (Johnson, Oxendine, Taub, & Robertson, 2013). Risk factors that have been empirically linked to suicide are gender, age, previous suicide attempts, psychiatric diagnosis, and childhood physical abuse (Whisenhunt et al., 2015). Warning signs indicate a near-term threat. Examples of warning signs include isolation, drastic changes in mood, hopelessness, anger and acting out, and increased use of alcohol and drugs. In short, warning signs for suicide are observable behaviors, episodic, and require immediate attention (Whisenhunt et al., 2015)

Frequently, college students who attempt of commit suicide suffer from depression or substance abuse. It is estimated that 90 to 95 percent of those who die by suicide have some form of treatable mental disorder at the time of their deaths (Taub & Thompson, 2013). College students at risk for suicide are often divided into two groups: student who come to college with an already diagnosed mental health problem and those who develop mental health problems while in college (Taub & Thompson, 2013). Many major psychiatric illnesses, including depression, anxiety, bipolar disorder, and schizophrenia, often do not manifest themselves until the late teens or early twenties (Taub & Thompson, 2013). Leaving home and going to college may increase existing psychological difficulties or bring about new ones (Taub & Thompson, 2013). In addition, poor sleep habits, experimentation with or abuse of drugs and alcohol,

combined with academic and social stress of college, can play a role in triggering or worsening

mental health problems in students (Taub & Thompson, 2013).

Certain groups of students are considered to be at a greater risk for mental health

problems than others. Research suggests that 10 percent of college athletes struggle with issues

that warrant counseling. College athletes have the additional stress of a busy schedule, a need to

perform at a high level, and pressure to fit in with their peers and teammates. International

students face the issue of feeling isolated being far away from family and friends, increasing

their risk of mental health concerns. Although women are more likely to consider suicide, men

are more likely than women to successfully complete suicide (Taub & Thompson, 2013).

Furthermore, students in the early years of college have been found to be at the greatest risk of

suicide (Taub & Thompson, 2013).

LGBT youth are also at risk for a variety of additional stressors on college campuses.

There is less authoritative data on suicides rates among LGBT persons because this information

is not typically reported on death certificates (Johnson et al., 2013). There is a strong relationship

between mental health issues, self-injury, and suicide and an individual's sexual orientation and

sexual identity within the LGBT population. LGBT young people typically report higher level of

depression and substance abuse, which are two of the greatest risk factors for suicide (Shadick,

& Akhter, 2013). Also researchers have found that LGBT college students are lonelier, and

endorse fewer reasons to live than their heterosexual peers (Taub & Thompson, 2013). The

LGBT population are not only at risk for mental health issues because they are members of a

sexual minority group, but also as a result of societal responses to their sexual orientation

(Johnson et al., 2013). Despite advances in coverage of LGBT rights in the media, there is still a

large stigma around being LGBT (Johnson et al., 2013).

College Counseling Centers

Losing a student to suicide is likely every college counselor's worst fear. It is key for college counselors to understand the difference between self-injury and suicide to be able to provide the most efficacious treatment (Whisenhunt et al., 2015). Mental health professionals who work with clients who self-injure need to be sure to assess for suicide risk. Although individual's assessment of their future self-injurious thought and behavior is correlated with their actual future behavior, looking at past self-injurious thoughts and behaviors is a better means of ascertaining the most probable course of future behavior (Janas & Nock, 2008). It should be noted that those who self-injure and have a history of attempting suicide may underestimate the lethality of their suicide attempts. Thus, mental health professionals may inadvertently and unknowingly misjudge the level of suicide risk in their clients (Whisenhunt et al., 2015).

As a result of the high prevalence of suicide, counselors should understand how to assess clients for suicide risk (Juhnke, Granello, & Lebrón-Striker, 2007). One technique used to assess individuals for immediate suicide risk is a mnemonic in a form of a question, "IS PATH WARM?" Each letter in the mnemonic corresponds with a risk factor that is frequently experienced by individuals in the months prior to a suicide (Juhnke et al., 2007). According to Juhnke et al., (2007) "IS PATH WARM?" stands for:

Suicide **I**deation: Does the client report active suicidal ideation or has she written about her suicide or death?

Substance Abuse: Does the client excessively use alcohol or other drugs, or has she begun using alcohol or other drugs?

Purposelessness: Does the client voice a lack or loss of purpose in life?

Anger: Does the client express feelings of rage or uncontrolled anger?

Trapped: Does she believe there is no way out of her current situation?

Hopelessness: Does the client have a negative sense of self, others, and her future?

Withdrawing: Does the client indicate a desire to withdraw from significant others, family, friends, and society?

Anxiety: Does the client feel anxious, agitated, or unable to sleep? Does the client report an inability to relax?

Recklessness: Does the client act recklessly or engage in risky activities, seemingly without thinking or considering potential consequences?

Mood Change: Does the client report experiencing dramatic mood shifts or states?

Counselors who use the "IS PATH WARM?" assessment or any similar suicide risk assessments should investigate thoroughly each risk factor with each client. The presence of any of the above risk factors should be a warning to the counselor and they should proceed with the necessary interventions to ensure the clients safety (Juhnke et al., 2007).

A college's focus should not be only on attending to an individual in crisis, but they also need to focus on the well-being of the entire student population (Drum & Denmark, 2012). However, limited resources on a college campus in comparison to their large student body can make reaching every student on a campus difficult, if not impossible. In addition, mental health resources that are available on college campuses can be underutilized by students who need them (King et al., 2015). According to study done by the American College Health Association, 75 percent of graduating students did not know about universities college counseling centers, and 92 percent reported that they had never received any information on suicide prevention (Catanzarite & Robinson, 2013). The avoidance or refusal of professional help among suicidal individuals is a phenomenon described as the help-negation effect. College students with more severe suicidal

ideation reported the lowest intentions to seek help from professionals (Czyz, Horwitz,

Eisenberg, Kramer, & King, 2013).

        In an effort to address this problem, the American Foundation for Suicide Prevention

(AFSP) developed and distributed an online screening program across multiple colleges across

the United States (King et al., 2015). The program sends an email to the entire student body,

offering them the opportunity to participate in a web-based screening. A trained counselor then

reviews students' responses and posts a confidential, personalized assessment that can be

accessed by the student. Once those steps are completed, students have the option to participate

in an online dialogue with a counselor and are encouraged to contact the counselor for an in-

person evaluation (King et al., 2015). An online screening tool can be an effective way for

campus counselors to reach a larger portion of students, however, an online screen tool relies

heavily on student participation and willingness to seek follow-up help. The underutilization of

mental health services among students at an elevated risk for suicide is highly problematic, as

those who seek help have been found to be less likely to make a suicide attempt (Czyz et al.,

2013).

Clinical Intervention and Problem-Solving Prevention

        The first commonly used campus suicide prevention strategy involves clinical

intervention aimed at identifying and assessing students who are already experiencing some

degree of suicidality, and to increase the number of those students who receive treatment (Drum

& Denmark, 2012). A critical component to this strategy is expert-based treatment of illness.

Expert-based treatment includes the use of licensed counselors who are trained in empirically

proven counseling theories and techniques (Drum & Denmark, 2012). Additional key

components of the clinical intervention strategy include the identification of suicidal students and

deaths by suicide as the particular problem requiring attention, the allocation of virtually all responsibility to college mental health services, and crisis resolution and restoration of premorbid function as fundamental goals. This clinical-intervention strategy has tended to dominate institutional efforts to prevent student suicide, despite the demand for a multifaceted, public health approach to preventing campus suicide (Drum & Denmark, 2012). However, a heavy reliance on the limited resources of college mental health centers limits the prevention technique's range of effectiveness.

The second commonly used campus strategy for suicide is the problem-solving strategy (Drum & Denmark, 2012). The problem solving strategy emphasizes the elements of campus ecology that can be amplified, modified, or eliminated to enhance the overall health of the entire student body. It also encourages the utilization of total and subpopulation proactive interventions that foster resilience (Drum & Denmark, 2012). This intervention enhances students' coping and self-management skills, which will help protect against suicidality. The fundamental goal is to avoid or reduce factors that contribute to personal distress and vulnerability (Drum & Denmark, 2012). Unlike the clinical-intervention strategy, the problem-solving strategy includes the well-being of the entire student population, rather than solely an individual already in crisis who seeks professional treatment (Drum & Denmark, 2012).

Ideally, a combination of the problem-solving strategy and the clinical-intervention strategy would be used on college campuses. An example of melding both strategies together is a strategy that embeds intervention within a comprehensive prevention strategy and helps interveners combine intervention methodology to specific types of preventative action. Within this framework, five types of preventative actions lie across three zones of intervention, according to purpose, timing, target population, and change in the methodology used (Drum &

Denmark, 2012). The five types of preventative actions include ecological prevention, proactive prevention, early intervention, treatment and crisis intervention, and lapse and relapse intervention. The three zones are prevention zone, which the ecological and prevention actions, the clinical intervention zone, which includes the early intervention and treatment and crisis intervention actions, and the recovery zone, which includes the lapse and relapse intervention actions (Drum & Denmark, 2012). The focus of interventions shifts from the environment to populations to individuals. Similarly, as the focus changes across the five types, a corresponding shift in intervention purpose and methodology is required (Drum & Denmark, 2012).

The first type of preventative action is ecological prevention. Ecological prevention goal is to improve ecological contributions to a populations overall health and decrease the universities role in the pathogenic process. Some examples include legislation, policy, and procedure adjustments, systematic interventions, and continuous process improvement (Drum & Denmark, 2012). The second type is proactive prevention, which focuses on populations with mixed levels of health and risk. The goal of the proactive approach is to reduce the prevalence of predisposed vulnerabilities and enhance individual assets. This approach is generally done through psychoeducational interventions (Drum & Denmark, 2012). Early intervention is the third preventative action. Early intervention focuses on the population of people with already identified warning signs. Its goal is to disrupt the further development of those symptoms and decrease the psychological impact of chronic stress. Examples of some early intervention techniques include, screening programs, individual counseling, and stress-management techniques (Drum & Denmark, 2012). The fourth preventative action is called treatment and crisis intervention. Treatment and crisis intervention aims to help individuals who are suffering from a diagnosable mental health concern or crisis. The goal is to successful treat the existing

disorder or crisis. Treatment and crisis interventions include crisis counseling, individual, group,

or inpatient treatment (Drum & Denmark, 2012). Lastly, the fifth approach is the lapse and

relapse intervention. The focus population of this approach is individuals who are in recovery.

The objective is to stabilize and strengthen the individual's recovery and resilience and also to

improve upon ecological preventative efforts to help sustain recovery. Peer-support systems and

continued counseling and psychoeducational interventions are techniques used in this approach

(Drum & Denmark, 2012).

Gatekeeper Training Program

Many students are more likely to disclose their mental health concerns to their peers

rather than a mental health professional, which makes it impossible for campus officials and

counselors to be aware of and intervene in the event of a potential suicide. (Cimini et al., 2014).

One of the most commonly employed programs for enhancing the identification and referral of

at-risk students is a gatekeeper training. Gatekeeper training programs vary in length and topic of

focus, but the core aspect of gatekeeper training is enhancing participant's knowledge, attitude,

and skills in identifying individuals at risk and referring them to appropriate services. Research

states that trained gatekeepers in the community, who have knowledge regarding how to identify

and respond to at-risk individuals, increase the likelihood of identification and access to mental

health services for individuals in need (Pasco, Wallack, Sartin, & Dayton, 2012).

One example of a gatekeeper training program is Campus Connect, which is a program

focused on enhancing gatekeepers' knowledge, awareness, and skills concerning college student

suicide. Campus Connect is a nationally recognized gatekeeper-training program exclusively

designed for gatekeepers in a college/university community. The program consists of a three-

hour training that incorporates active and experiential-based learning exercises, such as role

plays, to enhance active listening and communication skills, as well as knowledge and awareness

regarding suicide warning signs, referral sources, and guidance for directly asking about suicidal

thoughts (Pasco et al., 2012).

Peer Educator Programs

Although gatekeepers are important in suicide prevention, they are intended to act as

identification and referral agents and may not participate in large campus events. Compared to

gatekeepers, peer educators go through more hours of training and participate more in campus-

wide outreach events and presentations (Catanzarite & Robinson, 2013). Peer educators are

broadly defined as students who have been selected, trained, and designated by a campus

authority to offer educational services to their peers. These services are designed to assist peers

towards the attainment of their educational goals (Catanzarite & Robinson, 2013). Peer educator

programs are a cost effective way to assist schools in meeting their students social, emotional,

and educational needs. The programs must include purposeful training, as well as clearly defined

outcomes and procedures for peer educators, especially for suicide prevention peer educators. On

college campuses, typically peer educators are resident assistants, peer counselors, orientation

leaders, mentors, and peer tutors (Catanzarite & Robinson, 2013).

In general, research has shown that peer educators are effective because they are

perceived by other students as being like them enough to understand their problems and points.

As a result, it is easier for students to discuss sensitive information in a safe and non-judging

peer environment (Catanzarite & Robinson, 2013). Also peer educators increase student

attendance at college counseling centers, improves awareness about mental health issues and

campus resources relating to mental health (Catanzarite & Robinson, 2013). An example of a

peer educator program is a program called Friends Helping Friends. Peer educators in Friends

Helping Friends serve as role models for students by (1) raising general awareness about mental health issues, mental disorders, and warning signs of suicide; (2) mitigating stigma about mental health concerns and using counseling services; (3) promoting healthy, effective strategies for coping with mental health problems; (4) implementing outreach initiatives that connect students with mental health resources and counseling professionals on campus (Catanzarite & Robinson, 2013). Each peer educator was recruited and asked to submit an application; applicants showing potential were asked to come in for an interview. Accepted students then participated in a three-credit college course. The course taught basic peer education skills such as listening, communication, boundaries, presentation skills, and conflict resolution (Catanzarite & Robinson, 2013). Once students successfully completed the course, demonstrated knowledge of competencies, and performed outreach on campus, they became peer educators on campus to continue to provide support and outreach events.

Suicide Survivors

Suicide survivors are the people left behind who were connected to the individual who committed suicide. In the past, suicide survivors were considered to be limited to family members (Cerel, Bolin, & Moore, 2013). However, the impact of suicide extends beyond the individual's family members. On a college campus, it is likely that a suicide attempt or complete suicide could have effects on roommates, dorm-mates, fraternity/sorority members, classmates, counseling staff, and faculty (Cerel et al., 2013). Rough estimates say that one in every 64 Americans can be labeled a suicide survivor Adolescents who know a peer or family member who has attempted or died by suicide are especially likely to engage in risky behaviors including their own suicidal behavior (Cerel et al., 2013). The research supports the need for campus-based services directed at people who are affected by suicide.

Post-Suicide Intervention

After a suicide has occurred, a crisis intervention and other support are a critical part of a comprehensive suicide prevention response within college and university campuses (Cimini & Rivero, 2013). A suicide is a tragic event that effects the student's family, friends, peers, and a campus community as a whole. Colleges must be prepared to respond to the devastating effects of suicide through crisis response and post-suicide intervention efforts delivered to individuals, families, and the campus as a whole. The Suicide Prevention Resources Center defines post-suicide intervention as the provision of crisis intervention that is implemented after a suicide has occurred to address and alleviate possible effects of suicide (Cimini & Rivero, 2013). Equally important to post-suicide intervention efforts, is to prevent further loss of life and reduce the severity of potential mental health problems that may arise after a student suicide (Cimini & Rivero, 2013).

Post-suicide protocol development includes the identification of stakeholders to make up a crisis response and post-suicide intervention team and the development of guidelines that meet campus needs. A well-rounded crisis team can consist of university administrators; student affairs staff members; counseling professionals; media relations; and representatives from the local police department. In addition, some colleges include community representatives from local hospitals and psychiatric clinics (Cimini & Rivero, 2013). Once the team is identified, members should outline and document procedures that describe how the campus will provide support and assist students in crisis and enhance their safety. The team should also discuss confidentiality procedures. Not only should members of the crisis response team be aware of confidentiality, but all university staff should understand a students' right to privacy (Cimini & Rivero, 2013).

Conclusion

Overall, college student suicide is a problem across campuses throughout the United States. In the past, college campuses made limited attempts to provide their students with mental health services to negate suicidality in their student population. College's left the responsibility to the students to seek out mental health services if they were in an emotional crisis. However, students suffering from mental illness or who are in crisis often do not seek professional help. As time has progressed, more and more college campuses are proactively working to prevent suicide on campuses. Colleges are making efforts to reach all of their student body with their preventative measures, rather than wait until the student in crisis seeks their help. Although college student suicide prevention efforts are growing, suicide is still the third leading cause of death for this population. As a result, the question still lingers, what more can colleges be doing to prevent suicide in their students?

Author's Note

The topic of suicide among college students stems from my own experience in college. I have attended Winona State University for six years completing my undergraduate career in psychology and graduate career in school counseling. During the past six years I have been aware of multiple student deaths each academic year. For each student death the university sends out an email to the entire student body stating the student's name, when the memorial service is, and the counseling centers information. The email does not include the cause of death, but Winona State is a small university and word travels about the cause of death quickly. Personally, I find the process an impersonal formality, and a dismal way to acknowledge a person's life. Although I do understand that colleges and universities are legally limited to the amount of information they can release, I still feel that the problem of suicide can still be addressed without

pinpointing a specific student. With each email I have received throughout the years I wait to see if any additional suicide prevention efforts will be taken by the university, and in six years I have not seen a change.

The goal I have for this paper is to be a tool for colleges and universities to be informed of a variety of ways to bring suicide prevention to their campuses. Readers can use this paper as an introduction to different prevention methods and identify which methods may work for their campus with additional research and planning. Lastly, I hope college students themselves could read the content and advocate to their university to bring more awareness and prevention methods to their individual campuses.

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